DBHDS
Virginia Department of Behavioral Health and Developmental Services

Individual and Family Support Program FY 2015

Part I: APPLICANT INFORMATION (the individual on the waiting list)

Name _____ Social Security Number: _____
Date of Birth / / MM/DD/YYYY ☐Male ☐ Female
Which waiting list? ○ DD Waiver ○ ID Waiver
Address _____
Street City Zip Code County

Telephone Number(s) (h) (w) (c) _____

Part II: RESPONSIBLE PARTY (the individual or person filling out application who will be responsible for IFSP funds)

Name _____ Social Security Number: _____
Date of Birth / / MM/DD/YY ☐Male ☐ Female
Address _____
Street City Zip Code County

Telephone Number(s) (h) (w) (c) _____

Part III: WAITING LIST INFORMATION (choose one)

☐ I am an **individual** with intellectual/developmental disabilities who is on a ***waiting list*** for services.

☐ I am a **family member** of a child or individual with an intellectual/developmental disabilities who is on a ***waiting list*** for services.

If you are a family member, does the individual live with you on a permanent basis?
☐ Yes ☐ No If no, please give details: _____

If you listed yourself above as a family member what is your relationship to the individual for which you are applying:
☐Mother ☐Stepmother ☐Wife ☐Grandmother ☐Sister ☐Father ☐Stepfather ☐Husband ☐ Grandfather
☐Brother ☐Principal Caregiver ☐ Other _____

Part IV: ASSISTANCE AND RESOURCES

Will you need an interpreter to assist you with your application? ☐ No ☐ Yes
If yes, what language: _____

Individual and Family Support Program, DBHDS, PO Box 1797, Richmond, VA 23219
If you need an application in another language please call 804-225-3810 for assistance.
6/30/2014

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How did you hear about the Individual and Family Support Program?
☐ Case Manager/Support Coordinator ☐ Consumer Directed Services Facilitator
☐Center for Independent Living ☐ List serve
☐ Parent/Advocacy Group (_____)
☐ Website (_____)

Please tell us a little bit more about some of the funding or assistance you, as a person on the waiting list, may be receiving:

Healthcare Related -

☐ Private Insurance ☐ TRICARE military insurance
☐ Medicaid ☐ Insurance Settlement

State and Federally Funded Supports -

☐Center for Independent Living ☐ Comprehensive Services funding (FAPT)
☐ Early Intervention services (Part C) ☐ Special Education services (Part B)

Other Waivers -

☐ EDCD Waiver ☐ Day Support Waiver ☐ Tech Waiver
☐ Other

☐ **None**

Part V: Needs

Please select <u>categories</u> that are planned or anticipated to be needed for supports that you would or will use during the next 12 months.

- **If approved, you will be required to provide documentation for supports and services *after* the funds have been used and paid.**
- **If your needs change but they still meet the requirements of the IFS Program, you DO NOT have to ask for approval before spending your allocated funding.**
- **To ensure proper credit once funds are used*, you are required to provide receipts and any other documentation* to the IFS Program that support how funds were spent. Ensure that the name of the individual on the waitlist is written on the top of each page sent.**

You may mail OR FAX your receipts and documents to the IFS Program. Fax number 804-786-0076. See bottom of page for address. DO NOT FAX THIS APPLICATION. IT WILL NOT BE ACCEPTED!

Failure to follow the above procedures will impact your ability to access future funding from the IFS Program.

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I/We need…

☐ **Safe Living Environment**

(Examples) -

Respite

Wheelchair Ramp

Safety Fence

Bathroom Modifications/Door Widening

Handrails

Backup Generator

Family Education and Training

Home security items

Rental and Utilities Assistance (one month only)

Bedding/Furniture

Project Lifesaver

Other _____

☐ **Improved Health Outcomes**

(Examples)

Attendant Care

Dental Care

Eyeglasses/vision exam

Medication(s)

Nutritional support

Personal care Items/ pull ups

Therapeutic horseback riding/hippo therapy

Behavioral Therapy/ Applied Behavior Analysis

Doctor visits/care

Hearing aid/exam

Modified equipment (bicycle, wheelchair, stroller)

Occupational/Physical/Speech Therapy

Communication devices

Other_____

☐ **Community Integration**

(examples)

Childcare/after school care

Companion/peer support or mentoring

Self-advocate education/training

Supported Employment

Transportation services

Community activity

Day Support

Summer

Therapeutic recreation

Other_____

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☐ **Emergency supports to prevent -**

Hospitalization

Risk of homelessness

Risk of Institutionalization

How this will assist me to stay in my home or my family's home(required section):

_____

_____

_____

_____

Requested funding amount: _____

Frequency of payment: (Choose One)

☐ Lump Sum- one time payout

☐ Monthly- once per month. How many months? (No more than 12) _____

(A lump sum payment may affect your Medicaid eligibility).

PAYMENT OPTION:
IF YOU ARE RECEIVING MEDICAID AND NEED YOUR PAYMENT TO GO DIRECTY TO A VENDOR TO ENSURE FUNDING FROM THE IFSP WILL NOT AFFECT YOUR MONTHLY INCOME ALLOWANCE, PLEASE FILL IN THE INFORMATION BELOW:

Vendor /Individual providing the service information:
Name _____
Address _____
City _____ **State**_____ **Zip Code**_____
Employer Identification Number (EIN #) _____ **or**
Social Security Number of person hired to provide service(REQUIRED) _____

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Part VI: PROGRAM AGREEMENT (Signature required)

READ AGREEMENT CAREFULLY:

This is an agreement between the Applicant and DBHDS. The Applicant is eligible only if the individual with an intellectual or developmental disability is residing in his own home or the family home and is on the statewide waiting list for the Intellectual Disability Medicaid Waiver or the Individual and Family Developmental Disabilities Services Medicaid Waiver.

The Applicant agrees as follows:

- The Applicant acknowledges that the IFSP funds are provided only to the extent that such services are not available or cannot be funded through other public funding sources (including IDEA Part C - early intervention, IDEA Part B - public school services, Medicaid, Medicare, and EPSDT).
- The Applicant acknowledges that all money received through IFSP will be used solely for the purpose(s) documented on the Applicant's IFSP Application.
- The Applicant acknowledges that he/she must present receipts or other documentation to verify that IFSP funds were used to purchase only approved services or items ***within 30 days of receipt of funds*** and shall include the name of the provider of the goods/services and the individual's name. Any misrepresentations of the use of IFSP funds or attempts to misappropriate these funds are strictly prohibited and subject to legal action. The Applicant acknowledges that failure to provide documentation that IFSP funds are used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests.
- The Applicant acknowledges that any misrepresentation of the individual's/family's needs, and misappropriation of funds will result in immediate discontinuation of funding, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s). The individual may also no longer have access to IFSP funds in the future.
- The Applicant agrees to permit DBHDS representatives to conduct utilization reviews, including home visits, and shall cooperate fully with such reviews and provide all information requested by DBHDS.
- The Applicant acknowledges that IFSP funding is neither an entitlement nor a grant, and is provided to assist the individual to live at home with his/her family or independently in the community while waiting for waiver services.

☐ I have read, understood and agree to the terms and conditions of the Individual and Family Support Program and that all information provided is true and accurate to the best of my knowledge.

_____

Signature (Fiscally Responsible Person) Date